		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039347

Facility Name: Montgomery Health Care Center

Address: South Route 127, P.O. Box 309 (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

IDPA ID Number: 37-1323740

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton,IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	21	Skilled (SNF)	21	7,665	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,343	1,820	1,339	6,502	8
9	SNF/PED					9
10	ICF	12,731	6,928		19,659	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,074	8,748	1,339	26,161	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.96%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care, Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,339

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	139,797	8,623	6,279	154,699		154,699		154,699			1
2	Food Purchase		117,848		117,848		117,848		117,848			2
3	Housekeeping	75,417	9,297		84,714		84,714		84,714			3
4	Laundry	55,095	12,057		67,152		67,152	(216)	66,936			4
5	Heat and Other Utilities			72,891	72,891		72,891	611	73,502			5
6	Maintenance	34,910	9,337	20,567	64,814	266	65,080	550	65,630			6
7	Other (specify):* Sanitation Service			1,440	1,440		1,440		1,440			7
8	**TOTAL General Services**	305,219	157,162	101,177	563,558	266	563,824	945	564,769			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	818,327	52,751	1,569	872,647		872,647		872,647			10
10a	Therapy		3,157	123,803	126,960		126,960	(16,442)	110,518			10a
11	Activities	44,718	3,399	1,280	49,397		49,397		49,397			11
12	Social Services	25,305		760	26,065		26,065		26,065			12
13	Nurse Aide Training					325	325		325			13
14	Program Transportation		1,518		1,518		1,518		1,518			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	888,350	60,825	137,012	1,086,187	325	1,086,512	(16,442)	1,070,070			16
	C. General Administration											
17	Administrative	50,150	3,863	126,333	180,346	(523)	179,823	(48,562)	131,261			17
18	Directors Fees											18
19	Professional Services			32,707	32,707	1,833	34,540	17,290	51,830			19
20	Dues, Fees, Subscriptions & Promotions			27,293	27,293	(495)	26,798	(16,156)	10,642			20
21	Clerical & General Office Expenses	50,813	12,030	22,617	85,460		85,460	15,511	100,971			21
22	Employee Benefits & Payroll Taxes			176,824	176,824		176,824	10,058	186,882			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,507	8,507	(1,406)	7,101	(746)	6,355			24
25	Other Admin. Staff Transportation							2,476	2,476			25
26	Insurance-Prop.Liab.Malpractice			45,455	45,455		45,455	2,355	47,810			26
27	Other (specify):*											27
28	**TOTAL General Administration**	100,963	15,893	439,736	556,592	(591)	556,001	(17,774)	538,227			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,294,532	233,880	677,925	2,206,337		2,206,337	(33,271)	2,173,066			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montgomery Health Care Center #0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			103,884	103,884		103,884	6,414	110,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			219,565	219,565		219,565	(21,847)	197,718			32
33	Real Estate Taxes			31,959	31,959		31,959	784	32,743			33
34	Rent-Facility & Grounds							4,095	4,095			34
35	Rent-Equipment & Vehicles			1,225	1,225		1,225		1,225			35
36	Other (specify):* **Mortgage Ins.**			12,981	12,981		12,981		12,981			36
37	**TOTAL Ownership**			369,614	369,614		369,614	(10,554)	359,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,649	4,637	43,286		43,286		43,286			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		424		424		424		424			41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		39,073	59,934	99,007		99,007		99,007			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,294,532	272,953	1,107,473	2,674,958		2,674,958	(43,825)	2,631,133			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,146)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(762)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(254)	20		18
19	Entertainment	(1,600)	24		19
20	Contributions	(210)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,137)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,288)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,397)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(17,428)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,428)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (43,825)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Montgomery Health Care Center

ID# 0039347

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset expense reimbursements	$ (216)	4	1
2	Offset expense reimbursements	(17)	21	2
3	Eliminate PAC & lobbying dues	(1,953)	20	3
4	2002 IDPH license pd in 2001	(200)	20	4
5	Offset medicare billing income from other home	(3,902)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,288)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Health Care Center # 0039347 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(216)	0	0	0	0	0	0	0	0	0	0	(216)	4
5	Heat and Other Utilities	0	611	0	0	0	0	0	0	0	0	0	611	5
6	Maintenance	0	550	0	0	0	0	0	0	0	0	0	550	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(216)	1,161	0	0	0	0	0	0	0	0	0	945	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	(16,442)	0	0	0	0	0	0	0	0	(16,442)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	(16,442)	0	0	0	0	0	0	0	0	(16,442)	16
	C. General Administration													
17	Administrative	(762)	76,976	(124,776)	0	0	0	0	0	0	0	0	(48,562)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(614)	17,904	0	0	0	0	0	0	0	0	17,290	19
20	Fees, Subscriptions & Promotions	(16,754)	598	0	0	0	0	0	0	0	0	0	(16,156)	20
21	Clerical & General Office Expenses	(3,919)	19,430	0	0	0	0	0	0	0	0	0	15,511	21
22	Employee Benefits & Payroll Taxes	0	10,058	0	0	0	0	0	0	0	0	0	10,058	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,600)	854	0	0	0	0	0	0	0	0	0	(746)	24
25	Other Admin. Staff Transportation	0	2,476	0	0	0	0	0	0	0	0	0	2,476	25
26	Insurance-Prop.Liab.Malpractice	0	2,355	0	0	0	0	0	0	0	0	0	2,355	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,035)	112,133	(106,872)	0	0	0	0	0	0	0	0	(17,774)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,251)	113,294	(123,314)	0	0	0	0	0	0	0	0	(33,271)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Health Care Center # 0039347 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	6,414	0	0	0	0	0	0	0	0	0	6,414	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,146)	178	(18,879)	0	0	0	0	0	0	0	0	(21,847)	32
33	Real Estate Taxes	0	784	0	0	0	0	0	0	0	0	0	784	33
34	Rent-Facility & Grounds	0	0	4,095	0	0	0	0	0	0	0	0	4,095	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,146)	7,376	(14,784)	0	0	0	0	0	0	0	0	(10,554)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,397)	120,670	(138,098)	0	0	0	0	0	0	0	0	(43,825)	45

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00%	Jerseyville Nursing and Rehabilitation Ctr, Inc.	Jerseyville, IL	Wellington Mgmt Co	Chesterfield, MO	Management Co
David L. Kamler	10.00%	Westwood Hills Healthcare Center	Poplar Bluff, MO	Health Care Financial	Alton	Management Co
J. Terry Dooling	10.00%			C.J. Schlosser & Co.	Alton	Public Accountants
R.J. Tolliver	10.00%			NW Rehab, L.L.C.	Alton	Therapy Co
Jack A. Yeager	10.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Manangement Co.	60.00%	$ 611	$ 611	1
2	V	6	See Schedule VIII		Wellington Manangement Co.	60.00%	550	550	2
3	V	17	See Schedule VIII		Wellington Manangement Co.	60.00%	76,976	76,976	3
4	V	19	See Schedule VIII		Wellington Manangement Co.	60.00%	(614)	(614)	4
5	V	20	See Schedule VIII		Wellington Manangement Co.	60.00%	598	598	5
6	V	21	See Schedule VIII		Wellington Manangement Co.	60.00%	19,430	19,430	6
7	V	22	See Schedule VIII		Wellington Manangement Co.	60.00%	10,058	10,058	7
8	V	24	See Schedule VIII		Wellington Manangement Co.	60.00%	854	854	8
9	V	25	See Schedule VIII		Wellington Manangement Co.	60.00%	2,476	2,476	9
10	V	26	See Schedule VIII		Wellington Manangement Co.	60.00%	2,355	2,355	10
11	V	30	See Schedule VIII		Wellington Manangement Co.	60.00%	6,414	6,414	11
12	V	32	See Schedule VIII		Wellington Manangement Co.	60.00%	178	178	12
13	V	33	See Schedule VIII		Wellington Manangement Co.	60.00%	784	784	13
14	Total			$			$ 120,670	$ * 120,670	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 89,839	Wellington Management Co.	60.00%	$	$ (89,839)	15
16	V	17	Management Fees	34,937	Health Care Financial,L.L.C.	40.00%		(34,937)	16
17	V	19	Professional Services		C.J. Schlosser & Company, L.L.C.	40.00%	45,635	45,635	17
18	V	10a	Therapy Services	123,803	NW Rehab,L.L.C.	100.00%	107,361	(16,442)	18
19	V	34	See Schedule VIII		Wellington Management Co.	60.00%	4,095	4,095	19
20	V	19	Professional Services	27,731	C.J. Schlosser & Company, L.L.C.	40.00%		(27,731)	20
21	V	32	Interest	7,600	Health Care Financial,L.L.C.	40.00%	6,212	(1,388)	21
22	V	32	Interest	16,778	John H. Rothert	60.00%		(16,778)	22
23	V	32	Interest	713	Jerseyville Nursing & Rehabilitation	0.00%		(713)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 301,401			$ 163,303	$ * (138,098)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	John H. Rothert	President	Administrative	60.00%	196,523	9	24.00%	Salary	$ 60,499	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 60,499		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Court
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (314) 537-8447
Fax Number: (314) 537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	10,037,907	4	$ 2,596	$	2,362,773	$ 611	1
2	6	Maintenance	Accumulated Costs	10,037,907	4	2,337		2,362,773	550	2
3	17	Administrative	Accumulated Costs	10,037,907	4	327,022	327,022	2,362,773	76,976	3
4	19	Professional Services	Accumulated Costs	10,037,907	4	(2,609)		2,362,773	(614)	4
5	20	Fees, Subscriptions, and Promos	Accumulated Costs	10,037,907	4	2,540		2,362,773	598	5
6	21	Clerical and General Office Exp.	Accumulated Costs	10,037,907	4	82,544	48,491	2,362,773	19,430	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs	10,037,907	4	42,730		2,362,773	10,058	7
8	24	Travel and Seminar	Accumulated Costs	10,037,907	4	3,629		2,362,773	854	8
9	25	Other Admin Staff Transport	Accumulated Costs	10,037,907	4	10,521		2,362,773	2,476	9
10	26	Insurance - Prop., Liab., Malprac.	Accumulated Costs	10,037,907	4	10,004		2,362,773	2,355	10
11	30	Depreciation	Accumulated Costs	10,037,907	4	27,251		2,362,773	6,414	11
12	32	Interest	Accumulated Costs	10,037,907	4	756		2,362,773	178	12
13	33	Real Estate Taxes	Accumulated Costs	10,037,907	4	3,329		2,362,773	784	13
14	34	Rent - Facility & Grounds	Accumulated Costs	10,037,907	4	17,395		2,362,773	4,095	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 530,045	$ 375,513		$ 124,765	25

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Refinance Mortgage	$17,016.17	09/29/99	$ 2,415,500	$ 2,383,875	10/01/34	7.920%	$ 189,443	1
2	Nationsbank		X	Vehicle Loan	$451.84	11/02/00	4,784		10/02/01	7.500%	367	2
3								Loan Cost Amortization			4,664	3
4								Home Office Allocation			178	4
5								Interest Income			(3,146)	5
	Working Capital											
6	Health Care Financial,LLC	X		Working Capital	N/A	9/1/97	80,000	80,000	9/1/07	9.500%	6,212	6
7												7
8												8
9	TOTAL Facility Related				$17,468.01		$ 2,500,284	$ 2,463,875			$ 197,718	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,500,284	$ 2,463,875			$ 197,718	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	29,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,459	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,459	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	26,001	8
	1997	26,834	9
	1998	26,955	10
	1999	28,716	11
	2000	30,459	12

Line 2: 2000 Taxes Paid

Line 4: Accrual is based on 2000 taxes paid

Line 7: $31,959 + $784 (Home Office R.E. Tax Allocation) = Total R.E. Taxes of $32,743, Schedule V, Col. 8.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Health Care Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-100-716-75	NE PT SE SW	$ 30,458.60	$ 30,458.60
2.		Land Corp Limit Taylor Springs	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,458.60	$ 30,458.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	348,480	1994	$ 27,673	1
2					2
3	TOTALS	348,480		$ 27,673	3

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 962,086	$ 38,483	25	$ 38,483	$	$ 298,247	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed			1994	3,247	325	10	325		2,436	9
10	Air Conditioner			1994	76,140	7,614	10	7,614		57,105	10
11	Cabinets			1994	6,809	340	20	340		2,468	11
12	Doors			1994	2,337	117	20	117		857	12
13	Electrical			1994	4,601	230	20	230		1,644	13
14	Flooring			1994	25,850	2,585	10	2,585		18,932	14
15	Exterior Remodeling			1994	4,468	298	15	298		2,185	15
16	Interior Remodeling			1994	66,214	4,428	15	4,428		31,692	16
17	Nurse Call System			1994	1,960	131	15	131		948	17
18	Plumbing			1994	6,619	331	20	331		2,391	18
19	Roof			1994	29,619	2,962	10	2,962		21,965	19
20	Windows/Gutters			1994	60,254	4,017	15	4,017		29,792	20
21	Siding			1994	15,818	1,054	15	1,054		7,456	21
22	Landscaping			1994	3,134	313	10	313		2,324	22
23	Parking Lot			1994	29,107	2,911	10	2,911		21,747	23
24	Home Office Wallpapering/Flooring			1994	3,721		5			3,721	24
25	Flooring			1995	938	94	10	94		657	25
26	Metal Doors and Frames			1996	953	48	20	48		263	26
27	Metal Carport			1997	972	65	15	65		276	27
28	Carpet			1997	2,310	462	5	462		1,925	28
29	Dining Room Chair Rail			1997	2,230	149	15	149		595	29
30	Wallpapering			1997	4,830	966	5	966		3,944	30
31	Fire Doors			1997	593	30	20	30		119	31
32	Foliage & Fountains			1997	1,657	166	10	166		788	32
33	Interior Painting			1997	514	103	5	103		420	33
34	Shed			1997	315	31	10	31		128	34
35	Door Alarm System			1997	7,840	784	10	784		3,201	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sidewalk Replaced	1997	$ 650	$ 43	15	$ 43	$	$ 176	37
38	Beauty Shop Remodeling	1998	4,287	214	20	214		696	38
39	Wallpapering	1998	1,493	299	5	299		1,119	39
40	Shower Room Remodeling	1998	1,199	60	20	60		200	40
41	Mini Blinds Installed	1998	509	51	10	51		198	41
42	Shelving	1998	566	28	20	28		96	42
43	Baseboard Remodeling	1998	820	82	10	82		321	43
44	Water Heater	1998	6,040	403	15	403		1,309	44
45	Folding Doors	1998	456	45	10	45		147	45
46	Door Installed	1998	208	21	10	21		66	46
47	Wall Mounted Laundry Tub	1998	181	9	20	9		36	47
48	Shower Flooring	1998	401	40	10	40		123	48
49	Shed	1998	185	19	10	19		58	49
50	Flooring	1998	293	29	10	29		100	50
51	Air Conditioning Unit	2000	557	56	10	56		88	51
52	Asphalt Parking Lot	2000	2,360	236	10	236		314	52
53	Fire Doors	2001	1,534	60	15	60		60	53
54	Signage	2001	3,318	387	5	387		387	54
55	Cove Base	2001	1,006	56	10	56		56	55
56	Window Treatments	2001	7,272	848	5	848		848	56
57	Wallpapering	2001	37,693	4,350	5	4,350		4,350	57
58	Lobby Carpet	2001	1,433	191	5	191		191	58
59	Air Conditioner	2001	1,696	85	10	85		85	59
60	Home Office Wallpapering	1999	626		5	125	125	355	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,399,919	$ 76,649		$ 76,774	$ 125	$ 529,605	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 129,000	$ 13,530	$ 15,253	$ 1,723	5-20	$ 51,130	71
72	Current Year Purchases	50,869	1,825	1,843	18	5-15	1,843	72
73	Fully Depreciated Assets	261,360	9,983	9,983		5	261,360	73
74								74
75	TOTALS	$ 441,229	$ 25,338	$ 27,079	$ 1,741		$ 314,333	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1997 Minivan	2000	$ 7,589	$ 1,897	$ 1,897	$	4	$ 2,372	76
77	Home Office - Admin	1999 Taurus	Acq.'99, Sold'00			731	731	4		77
78	Home Office - Admin	2000 Taurus	2000	5,606		1,402	1,402	4	1,869	78
79	See Attached Schedule			9,660		2,415	2,415	4	3,978	79
80	TOTALS			$ 22,855	$ 1,897	$ 6,445	$ 4,548		$ 8,219	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,891,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,884	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,298	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,414	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 852,157	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ 1,225 Description: Ice Machine - $1,189, Gas Tank - $36
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 75

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 100

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments			275	275
8	Nurse Aide Competency Tests		50		50
9	TOTALS	$	$ 50	$ 275	$ 325
10	SUM OF line 9, col. 1 and 2 (e)	$ 50			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	1857	hrs	$ 46,129		$	$ 2,258	1,857	$ 48,387	1
2	Licensed Speech and Language Development Therapist	10a,8	544	hrs	18,034			8	544	18,042	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,8	1723	hrs	43,198			891	1,723	44,089	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				38,649		38,649	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Laboratory Fees Other (specify): X-Rays	39,3 39,3					4,448 189			4,448 189	13
14	TOTAL				$ 107,361		$ 4,637	$ 41,806	4,124	$ 153,804	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Montgomery Health Care Center **#** 0039347 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 136,607	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,935)	397,117		3
4	Supply Inventory (priced at cost)	14,042		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,108		6
7	Other Prepaid Expenses	2,414		7
8	Accounts Receivable (owners or related parties)	14,081		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 592,369	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,250		12
13	Land	62,924		13
14	Buildings, at Historical Cost	1,360,321		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	433,520		16
17	Accumulated Depreciation (book methods)	(832,461)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	88,877		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	152,733		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,271,164	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,863,533	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 272,499	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,190		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,138		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Related Liabilities	171		36
37	Due to Related Parties	357,253		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 762,751	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	192,793		39
40	Mortgage Payable	2,383,875		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,576,668	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,339,419	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,475,886)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,863,533	$	48

***(See instructions.)**

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,331,962)	1
2	Restatements (describe):		2
3	**PY bad debt adjustment recorded after cost report filed**	(12,906)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,344,868)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(131,018)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (131,018)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,475,886)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,292,879	1
2	Discounts and Allowances for all Levels	3,247	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,296,126	3
	B. Ancillary Revenue		
4	Day Care	19	4
5	Other Care for Outpatients	17,434	5
6	Therapy	220,015	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 237,468	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(24)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,693	19
20	Radiology and X-Ray	189	20
21	Other Medical Services		21
22	Laundry	3	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,861	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,146	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,146	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,339	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,339	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,543,940	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	563,558	31
32	Health Care	1,086,187	32
33	General Administration	556,592	33
	B. Capital Expense		
34	Ownership	369,614	34
	C. Ancillary Expense		
35	Special Cost Centers	43,710	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,674,958	40
41	**Income before Income Taxes (line 30 minus line 40)****	(131,018)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (131,018)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet filed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,905	1,905	$ 39,601	$ 20.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,122	4,509	80,640	17.88	3
4	Licensed Practical Nurses	19,210	21,194	267,339	12.61	4
5	Nurse Aides & Orderlies	48,414	50,204	405,312	8.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,780	5,058	44,718	8.84	10
11	Social Service Workers	1,856	2,115	25,305	11.96	11
12	Dietician					12
13	Food Service Supervisor	1,689	1,949	21,953	11.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,420	18,269	117,844	6.45	15
16	Dishwashers					16
17	Maintenance Workers	4,135	4,339	34,910	8.05	17
18	Housekeepers	10,854	11,514	75,417	6.55	18
19	Laundry	9,377	9,727	55,095	5.66	19
20	Administrator	2,261	2,261	50,150	22.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,246	4,556	50,813	11.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,202	2,315	25,435	10.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,471	139,915	$ 1,294,532 *	$ 9.25	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	138	$ 6,279	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	16	712	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	857	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,280	11,3	44
45	Social Service Consultant	19	760	12,3	45
46	Other(specify) Advisory Board	N/A	1,350	17,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	205	$ 20,838		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jerry Nelson	Administrator	0.00%	$ 50,150
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,150

B. Administrative - Other

Description		Amount
Wellington Management Company	Management Fees	$ 89,839
Health Care Financial, L.L.C.	Management Fees	34,937
Advisory Board fees		1,350
Travel reclassed out of line 17		207
TOTAL (agree to Schedule V, line 17, col. 3)		$ 126,333
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
Ted Frapolli	Legal Services	$ 831
C.J. Schlosser & Company,L.L.C.	Accounting Services	27,731
Hughes & Associates, CPA	Audit Fees	4,145
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,707

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,422
Unemployment Compensation Insurance	25,916
FICA Taxes	98,291
Employee Health Insurance	5,192
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Relations	6,564
Home Office Employee Benefits	10,058
Employee Disability Insurance	790
Employee Dental Insurance	649
TOTAL (agree to Schedule V, line 22, col.8)	$ 186,882

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,325
Health Care Worker Background Check	
(Indicate # of checks performed 38)	456
Dues & Subscriptions	2,230
Licenses & Fees	524
Bank Service Charges	1,366
IHCA Dues	3,943
Home Office Dues, Fees & Subscriptions	598
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,642

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,278
Seminar Expense	2,223
Home Office Travel and Seminar	854
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,355

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montgomery Health Care Center # 0039347 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $3,943**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,748**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **19%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **None**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Hughes & Associates, CPA's** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

MONTGOMERY HEALTH CARE CENTER
ADJUSTMENTS
ATTACHMENT TO SCHEDULE VI
12/31/01

DESCRIPTION	LINE #	INCREASE (DECREASE)
LAUNDRY	4	(216)
CLERICAL AND GENERAL OFFICE EXPENSE	21	(17)
To offset expense reimbursements received		
INTEREST	32	(3,146)
To offset interest income against related expense		
FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(1,953)
To eliminate PAC dues & lobbying dues		
FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(210)
To eliminate donations		
FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(14,137)
To eliminate promotional advertising		
FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(200)
To eliminate 2002 IDPH license paid in 2001		
FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(254)
To eliminate tax penalties paid		
ADMINISTRATIVE	17	(762)
To eliminate sales tax paid		
TRAVEL AND SEMINAR	24	(1,600)
To eliminate non-allowable meals and entertainment		
CLERICAL & GENERAL	21	(3,902)
To offset Medicare billing income from other home		
INTEREST	32	(8,313)
To eliminate non-care related interest		

MONTGOMERY HEALTH CARE CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/01

DESCRIPTION	LINE #	INCREASE (DECREASE)
PROFESSIONAL FEES	19	1,833
TRAVEL AND SEMINAR	24	(1,833)
To reclassify expenses for Medicare billing consultant to proper line		
ADMINISTRATIVE	17	(207)
TRAVEL AND SEMINAR	24	207
To reclassify travel to proper line		
ADMINISTRATIVE	17	(316)
MAINTENANCE	6	266
NURSE AIDE TRAINING	13	50
To reclass maintenance supplies & CNA test fee to proper line		
FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(495)
TRAVEL AND SEMINAR	24	220
NURSE AIDE TRAINING	13	275
To reclass expenses to proper lines		

MONTGOMERY HEALTH CARE CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/01

SALE OF USED A/C	60
GARNISHMENT FEES	62
MEDICARE BILLING FOR OTHER HOME	3,902
PAY PHONE INCOME	17
$ RECEIVED FOR H.S. STUDENT EMPLOYED	216
OTHER MISCELLANEOUS INCOME	82
	4,339

MONTGOMERY HEALTH CARE CENTER
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO MEDICAID COST REPORT
12/31/01

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/ TRAVEL/MEALS
Monica Watson	RN	4/23-27, 2001	Springfield, IL	CNA Instructor Course for RN's	Lincoln Land Community College	140	142
Carla Lipe	DON	8/01	Lake Ozark, MO	DON Convention	Missouri Health Care Assoc.	67	326
Various	Various	1,8&9/2001	Hillsboro, IL	CPR Courses	Red Cross	360	
Shannon Moore	MDS Coordinator	10/11/2001	Springfield, IL	MDS-By the Book	Illinois Health Care Association	85	
Birdie Scroggins	Activities	10/2/2001	Decatur, IL	IAPA Convention	IL Activity Professionals Association	140	167
Jerry Nelson	Administrator	5/31/2001	Mt. Vernon, IL	IOC Survey Seminar	HSC Inc.	75	
Ann Ridings	Dir. of Operations	5/31/2001	Mt. Vernon, IL	IOC Survey Seminar	HSC Inc.	75	
					Total Seminars	942	635
					Total Seminar Lodging/Travel/Meals	635	
					IHCA Convention	695	
					Training Manuals	365	
					Misc. Travel & Seminar	221	
					Other Travel Expense <$250 each	2,643	
					Home Office Travel & Seminar	854	
					Total Travel and Seminar, Line 24	6,355	